ASN LEADING THE FIGHT AGAINST KIDNEY DISEASE

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June 18, 2010

Department of Health and Human Services
200 Independence Avenue SW
Room 736-E
Washington DC 20201

Attn: MCC Strategic Framework

Re: Draft HHS Strategic Framework on Multiple Chronic Conditions (FR-Doc. 2010-11956)

Dear Ladies and Gentlemen,

On behalf of the American Society of Nephrology (ASN), a not-for-profit organization of 11,000 physicians and scientists dedicated to helping nephrologists provide the highest quality of patient care possible, thank you for the opportunity to provide comment on the Health and Draft Department of Human Services (HHS) Strategic Framework on Multiple Chronic Conditions 2010-2015.

ASN is committed to promoting excellence in the care of patients with kidney disease and advancing innovative research related to nephrology. The society appreciates the HHS Interagency Workgroup's willingness to obtain broad input regarding the development of the initiative to improve the health of Americans with concurrent multiple chronic conditions (MCC).

Recognizing the prevalence of and costs associated with MCC, ASN applauds HHS's initiative to improve the health and quality of life for individuals with concurrent chronic conditions. MCC such as arthritis, chronic respiratory conditions, diabetes, heart disease, hypertension, and mental health conditions place significant burden on individuals with as well as the health system in general. Particularly in light of the aging population, improving health outcomes and reducing costs for patients with MCC is imperative. *To meet this goal, it is essential that chronic kidney disease (CKD) and end-stage renal disease (ESRD) be included in the HHS Strategic Framework on Multiple Chronic Conditions.*

Chronic Kidney Disease and End-Stage Renal Disease

Nearly 30 million Americans—13 percent of the population—have chronic kidney disease (CKD), but most people are unaware they have it. Medicare spends $24 million annually to treat people with CKD, yet kidney disease remains the ninth leading cause of death in the U.S.[i,ii] CKD is treatable and preventable, but without proper care it can lead to other serious chronic conditions and often progresses to ESRD. Furthermore, each stage of the CKD timeline—risk factors, initiation, progression, and treatment, and outcomes—is marked by health disparities in racial and ethnic minority populations.

The importance of CKD as a risk multiplier for morbidity and mortality has been increasingly recognized over the past decade.[iii] CKD is a common co-morbid condition among patients with other chronic conditions, particularly hypertension, cardiovascular disease, congestive heart failure, diabetes, and peripheral vascular disease. Complex causal relationships exist between CKD, heart disease, and diabetes; each may be caused by, or be a complication of, one or both of the others. Hypertension can cause significant kidney damage—and CKD can also accelerate the progression of heart disease. Eighty percent of kidney patients have hypertension, and patients on dialysis are 10 to 30 times more likely to die from heart disease compared to the general population. Diabetes is the most common cause of kidney failure, accounting for 44 percent of new ESRD cases, and can be found in up to 23% of patients with diabetes.[iv]

Despite the prevalence of kidney disease and the chronic conditions which often cause or result from it, lack of public and patient awareness of CKD—and suboptimal recognition of cardiovascular disease and other complications as outcomes of CKD—persist.[v]

Through its Strategic Framework, HHS has significant opportunity to advance understanding of and care for the millions of Americans with MCC, including CKD.

ASN supports the four overarching goals established in the Workgroup's draft framework. The society looks forward to collaborating with HHS to achieve them, particularly as they relate to prevention and care of kidney disease and its most common co-morbidities—diabetes and heart disease.

Goal #1

ASN encourages HHS' goal to provide health professionals with more data and tools to care for individuals with MCC. More evidence on the relationship between kidney disease, diabetes, and heart disease, as well as on best practices in CKD care, will be an important component of better enabling providers to best prevent and manage MCC in their patients. *Also paramount in this effort will be making available more information on the indications and benefits of timely nephrologist referral, particularly for patients with MCC.* Late referral may lead to suboptimal pre-ESRD care and greater mortality.[vi] Given the causal relationships between kidney disease and other chronic conditions, timely identification and management of CKD is a crucial aspect of maintaining health and quality of life for patients with or at risk for MCC. Better guidelines regarding the timing of referral will be an absolute necessity.[vii] Future activities may also include training programs on CKD directed at internists and residents and efforts to increase coordination between primary caregivers and nephrologists.[viii]

Goal #2

Engaging individual patients in medical decision-making and self-care is an important component of managing risk factors and preventing development of additional chronic conditions. Because CKD is a risk factor for—and is often concurrent with—other chronic conditions, it is particularly important to involve patients in managing and slowing the progression of the disease. Evidence suggests that CKD patients want to self-manage their illness in collaboration with health care providers, and community-based initiatives show promise in improving CKD management, particularly among racial and ethnic minorities.[ix,x, xi]

Because certain minority populations face higher risks of developing CKD, due in part to elevated rates of hypertension and diabetes, it will be especially important to engage minority communities in MCC self-care and community-based efforts. For instance, African Americans with diabetes are 3 to 5 times more likely to develop kidney disease compared to the general population—and Mexican Americans and Native Americans are 6 times more likely. *ASN suggests the strategic framework include kidney disease among the chronic conditions addressed in MCC patient self-care services and related research.*

Goal #3

ASN recognizes the potential to improve care coordination and outcomes for patient with MCC through changes to delivery and payment programs. The frequent use of subspecialists in the face of low primary care is now recognized as a problem in the United States, as is the need to better synchronize care of those with MCC. Particularly in light of the growing CKD population, it will be important for the HHS Initiative to ensure new patient care management models facilitate collaboration and coordination between primary care physicians (PCPs) and nephrologists around CKD.[xii]

ASN has explored the concept of patient care delivery models— including the patient-centered medical home—in which PCPs, subspecialists, and patients might interact within a 'medical neighborhood' to provide comprehensive care. Given that kidney disease is commonly concurrent with multiple other chronic diseases, fostering coordination between nephrologists and primary care providers, internists, cardiologists, endocrinologists should be considered by the Workgroup in relation to Goal number three. *The society suggests HHS involve nephrology societies and nephrologists in general in the development of chronic disease care models under the Strategic Initiative.*[xiii]

ASN lauds the goal of preventing occurrence of additional chronic conditions in persons with MCC, reiterating that kidney disease is both a cause and consequence of heart disease and that diabetes is its leading cause. More research on the relationships between these chronic diseases and the most effective therapies for patients with these conditions should be of utmost importance within the context of the HHS Initiative.

Goal #4

Substantial opportunities for research in the care of individuals with MCC including CKD and ESRD exist, and ASN concurs that supporting such investigation is vital. Like many other chronic conditions, patients with kidney disease have often historically been excluded from important clinical trials. Strategies to prevent exclusion of MCC patients in clinical trials are necessary to ensure safe, appropriate therapy for this vulnerable patient population. This is particularly important given the growing number of Americans whose chronic conditions include CKD or ESRD. Patients with impaired kidney function sometimes excrete drugs more slowly—or less fully—than those with normal kidney function, and it will be important to ensure clinical trials properly assess treatments for these patients.

ASN supports the HHS goal of increasing clinical and patient centered health research on MCCs, and strongly encourages the Department to include kidney disease in these efforts. Given the significant health disparities that exist at every stage of CKD—from risk factors through outcomes—in certain populations, the society is also strongly supportive of research that more clearly elucidates differences between and opportunities for intervention in MCC among various racial/ethnic and socio-demographic groups.

On behalf of ASN, thank you again for your willingness to consider our comments for the Draft HHS Strategic Framework on Multiple Chronic Conditions. The society looks forward to collaborating with the Department in its efforts to improve outcomes for patients with MCC in the future. ASN would be pleased to discuss these comments with the Workgroup if it would be helpful.

Again, thank you for your time and consideration. To discuss ASN's comments, please contact ASN Director of Policy and Public Affairs, Paul C. Smedberg, at (202) 416-0640 or at psmedberg@asn-online.org.

Sincerely,

Sharon Anderson, MD, FASN
President

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[i] National Kidney Foundation. Kidney Disease by the Numbers. http://www.kidney.org/news/pubpol/pdf/KIDNEY_DISEASE_BY_THE_NUMBERS.pdf

[ii] The Centers for Disease Control and Prevention. Leading Causes of Death. http://www.cdc.gov/nchs/fastats/lcod.htm

[iii] USRDS. 2009 Annual Report.

[iv] Cavanaugh K. Diabetes Management Issues for Patients With Chronic Kidney Disease. *Clinical Diabetes*. July 2007.

[v] Rettig R et al. Chronic Kidney Disease in the United States: A Public Health Imperative. *Clin J Am Soc Neph*

[vi] Agrawal V at al. Perception of Indications for Nephrology Referral among Internal Medicine Residents: A National Online Survey. *Clin J Am Soc Neph.* 2009.

[vii] DuBose T et al. The Neprhology-Primary Care Interface: Providing Coordinated Care for Chronic Kidney Disease. *Neph SAP* 2010.

[viii] Rettig R et al. Chronic Kidney Disease in the United States: A Public Health Imperative. *Clin J Am Soc Neph.*

[ix] Constantini L. The self-management experience of people with mild to moderate chronic kidney disease. Nephrol Nurs J. 2008.

[x] Detroit Urban Research Center: Current Project Matrix - Racial and Ethnic Approaches to Community Health (REACH) Detroit Partnership. Accessed 2010. http://www.detroiturc.org/index.php?option=com_content&view=article&id=18#24

[xi] AHRQ Activities Using Community-Based Participatory Research to Address Health Care Disparities. AHRQ Publication No. 09-P012, September 2009. Agency for Healthcare Research and Quality. http://www.ahrq.gov/research/cbprbrief.htm

[xii] DuBose T et al. The Nephrology-Primary Care Interface: Providing Coordinated Care for Chronic Kidney Disease. *Neph SAP* 2010.